STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE		ETED		
		155773			·	06/13/	2012
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	t		l	ADDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRAC	E AT SOLARBRON	NTHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0000						•	
	This visit was f	or a Recertification and	F00	00	Bysubmitting the enclosed		
			100	00	material we are not admitting t	he	
	State Licensure	e Survey.			truth oraccuracy of any specifi		
					findings or allegations. We	_	
	Survey dates: June 4, 5, 6, 7, 8, 11, 12, 13, 2012				reserve theright to contest the		
					findings or allegations as part	of	
					anyproceedings and submit th		
	Facility number	r [.] 010930			responses pursuant to our		
	Provider numb				regulatoryobligations. The faci		
					request that the plan of correc		
	AIM number: N	N/A			beconsidered our allegation of	•	
					compliance effective July 16,		
	Survey team:				2012 tothe annual licensure		
	Amy Wininger,	RN, TC			survey conducted on June 4 through June 13, 2012		
	Diane Hancock	k, RN (June 4, 5, 6, 7,			tillough Julie 13, 2012		
	8, 11, 12, 2012	2)					
	Vickie Ellis, RN	•					
	Barbara Fowle						
	Daibara Fowle	I, KIN					
	Census bed type						
	SNF:	33					
	Residential:	29					
	Total:	62					
	Census payor	type:					
	Medicare:	19					
		43					
	Total:	62					
	Residential sar	nple: 7					
	These deficien	cies also reflect state					
	findings cited in	n accordance with 410					
	IAC 16.2.						
	1, (0 10.2.						
			_L				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

010930

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/13/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MCDOWELL RD EVANSVILLE, IN 47712				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTOR CROSS-REFERENCE)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Quality review Williams, RN	6/19/12 by Suzanne					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OZJH11

Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155773	A. BUILDING	00	06/13/2012
		100.10	B. WING	ADDRESS CITY STATE 7ID CODE	00/10/2012
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE CDOWELL RD	
TERRAC	E AT SOLARBRON	N THE		VILLE, IN 47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0157 SS=D	A facility must in resident; consultant if known, no representative of member when the resident white potential for intervention; a serident's physical status (i.e., a defor psychosocial threatening concomplications); a significantly (i.e. existing form of consequences, of treatment); or discharge the respecified in §483.	NE/ROOM, ETC) neediately inform the t with the resident's physician; otify the resident's legal or an interested family here is an accident involving the results in injury and has requiring physician ignificant change in the cal, mental, or psychosocial terioration in health, mental, status in either life ditions or clinical a need to alter treatment , a need to discontinue an treatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a).			
	representative o when there is a assignment as s a change in resi State law or reg paragraph (b)(1	known, the resident's legal or interested family member change in room or roommate specified in §483.15(e)(2); or dent rights under Federal or ulations as specified in) of this section.			
		representative or interested			
	record review, ensure the phy notified of a sig	ervation, interview and the facility failed to vician and family were gnificant weight loss, for s reviewed for weight	F0157	F157 Whatcorrective action(s) will accomplished for those residents foundto have been affected by the deficient practice?	

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Event ID: OZJH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155773			06/13/2012
			B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	₹		1 MCDOWELL RD	
TEDDAC	E AT SOLARBRO	JI THE		NSVILLE, IN 47712	
TERRAC	E AT SOLARBROI	N IIIE	EVA	1103 VILLE, IIV 477 12	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	ICY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		le of 3 who met the		It is the practice Solarbron to	
	criteria for wei	ght loss. (Resident		assure that thephysician and family are notified appropria	
	#31)			accordance withthe guidelin	
				including significant weight I	
	Finding include	es:		The corrective action taken	
				those residents found tobe	
	Resident #31's	clinical record was		affected by the alleged defic	ient
		6/12 at 2:45 p.m. The		practice include:	
		ed the resident was		Resident#31 physician and	- I
				have been notified appropriately related to the resident's current	- 1
		5/11/12. Diagnoses		weight.	ent
	•	vere not limited to,		How will other residents ha	avina
		/, status/post valve		the potentialto be affected	
	l •	n coumadin [blood		the same deficient practice	-
	thinner], urinar	y retention, congestive		identified and whatcorrect	
	heart failure, h	ypertension, chronic		actions will be taken?	
	back pain, ane	mia, pneumonia,		Other residents that have th	
	depression, an	d heart disease.		potential to be affectedhave	been
				identified by: All residents will be reviewed	d to
	Physician's ord	ders, signed 5/29/12,		assure thatphysician/familie	
	_	esident was on a		have been notified appropria	
	regular diet as	of 5/16/12.		of any changesincluding	
				significant weight loss.	
	Orders for Spe	ech Therapy for		What measures will be put	
	•	ation and treatment		place or whatsystemic cha	
1				will be made to ensure tha	
	were obtained	UII 3/22/12.		deficient practicedoes not recur?	
	0-07/40	0.00		The measures or systematic	,
	On 6/7/12 at 1	-		changes that have been put	
		h tray was observed on		place to ensure that the alle	
		ble, covered. A		deficient practice does notre	ecur
		inician was drawing		include:	
	blood. The Sp	eech Therapist entered		Allnurses will be in-serviced	
	the room. She	was interviewed on		relating to the importance ofphysician/family notification	n with
	6/7/12 at 12:12	2 p.m. She indicated		significant changes including	
		the resident for		thepresence of weight loss.	
		irst, but discontinued		the interdisciplinary team re	
	ı	,	1	· · · ·	

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Event ID: OZJH11

Facility ID: 010930

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	I DDIG	00	COMPL	ETED
		155773	A. BUI B. WIN	LDING		06/13/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ICDOWELL RD		
TERRAC	E AT SOLARBRO	N THE			SVILLE, IN 47712		
	L AT SOLANDINO	V 111L		LVANO	7 ILLE, III 477 12		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	because he wa	as swallowing well and			anyresidents with weight loss	as	
	was only treati	ng him for cognitive			well as any other type of		
	improvement.	She indicated she was			significantchange, they are	•	
	iust checking c	on him that day			reviewing all documentation to assure that thephysician/fami		
	, ·	id a spell where he was			was notified appropriately. Th	-	
		orning and she was			dietician has beennotified that		
	1	orning and sine was			they are to notify nursing		
	concerned.				administration of anyidentified	j	
					weight loss with		
		dated 5/31/12 at 12:35			recommendations.		
	p.m. indicated	the following:			How will thecorrective actio	n	
	"Resident's wt	[weight] 5/30/12 189.8			be monitored to ensure the		
	lbs [down] 15 l	bs X 1 wk. On regular			deficient practice willnot red	:ur,	
		es 50-100% of meals.			ie, what quality assurance	•	
		etic medication] 20 mg			program will be put into place		
	_	since adm). IBW			The corrective action taken to monitor performance toassure		
	,	•			compliance through quality	7	
	1 -	eight] 200 +/- 5 lbs.			assurance is:		
		ing assess and notify			APerformance Improvement	ΓοοΙ	
	MD."				has been initiated that will be		
	6/4/12 1047 [1	0:47 a.m.] "Wt 6/3/12			utilizedto review weight losse:	s to	
	191.2 lbs [up]	1.4 lbs X 4 days."			assure that the physician/fam	ily	
					have beennotified in accordar		
	The nurses' no	otes were reviewed, at			with the regulation. The tool w		
		there was no indication			randomlyreview 5 residents (i		
		vas notified or nursing			applicable) with known weight		
	1 .	vas notined of nursing			loss. NursingAdministration, of designee, will complete this a		
	assessed.				weekly x3,monthly x3, then	uuit	
					quarterly x3. Any issue identif	ied	
		terviewed on 6/7/12 at			will beimmediately corrected.		
	-	indicated the resident			Quality Assurance Committee		
	was a daily we	ight and his weight was			reviewthe tool at the schedule) d	
	187.2 pounds	on that date.			meeting following the complete		
					of thetool with recommendation	ons	
	On 6/7/12 at 4	:00 p.m., Resident			as needed.		
		as reviewed again.			Thedate the systemic chang	jes	
		•			will be completed:		
		indication the physician			July16, 2012		
	was called for	weight loss. A					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPLE	
		155773	A. BUI B. WIN	LDING IG		06/13/2	
NAME OF I	PROVIDER OR SUPPLIEI		D. WIII		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Registered Die	etitian note, dated					
	6/7/12 at 11:03	3 a.m., indicated,					
	"Resident's wt	6/6/12 186.2 lbs					
		X 1 wk, [down] 22.2 lbs					
	-	mission]. Will request					
		ritional supplement] 90					
	_	meters] TID [three 't [due to] wt. loss.					
		ntakes generally					
	50-100% of me						
	00 100 / 0 01 1110	34.0.					
	On 6/8/12 at 1	0:00 a.m., LPN #2 was					
	interviewed. S	the indicated when the					
		recommendations, she					
		em herself to the					
	1	e reviewed the record					
	•	ysician had been					
	notified on 5/3	int loss. She reviewed					
		xes in it. She indicated					
		ing well when he first					
		ty and had a lot of fluid					
	taken off during	-					
	hospitalization	, prior to admission.					
	She further ind	licated she usually					
		gs, so notification of					
		vas not always passed					
	on.						
	On 6/8/12 at 1	0:10 a m the					
		etitian was interviewed					
	_	she reviewed the					
		eek and wrote the note					
		sing to assess the					
		otify the physician.					

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Event ID: OZJH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155773	B. WING			06/13/	2012
NAME OF F	DOWNER OF GUIDNI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			1701 M	CDOWELL RD		
	E AT SOLARBRON				VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		she was then off work.					
	She re-evaluated him this week and						
		reight loss. She					
		adding med pass					
		e to continued weight					
		cated she spoke to LPN					
		hat day, and LPN #1					
		call out to the doctor					
	and would also	•					
	• •	the resident when the					
		ack. Review at the					
		no documentation of					
		eing notified of the					
	_	e had been notified of					
	_	havior and had					
	ordered some	labwork. No orders for					
	supplement we	ere noted.					
	The policy and	procedure for Change					
	of Condition No	otification, dated 2003,					
	was provided b	by the Director of					
		12 at 12:46 p.m. The					
	policy indicated	d, "It is the policy of this					
	facility to notify						
		rsician, Resident's legal					
		or interested family					
	•	there is a change in					
		condition." "Areas that					
		tion of the Physician,					
	Resident, Resi	-					
		and/or interested					
	· ·	:Weight loss."					
	3.1-5(a)(2)						
	3.1-5(a)(3)						
	σ. ι σ(α)(σ)						

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Event ID: OZJH11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CO A. BUILDING B. WING	00	06/13	ESURVEY LETED 3/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	ODE	
TERRAC	E AT SOLARBRON	I THE		VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE

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Event ID: OZJH11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		155773	A. BUIL B. WING			06/13/	2012
			b. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CDOWELL RD		
TERRAC	E AT SOLARBRON	ITHE			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
F0272 SS=D	The facility must periodically a constandardized repeach resident's for a seessment of a RAI specified by must include at lidentification and Customary routing Cognitive pattern Communication; Vision; Mood and behave Physical function Continence; Disease diagnost Dental and nutrity Skin conditions; Activity pursuit; Medications; Special treatment Documentation of regarding the adiabate in the standard sees and seed and see	conduct initially and mprehensive, accurate, producible assessment of unctional capacity. ake a comprehensive resident's needs, using the the State. The assessment east the following: d demographic information; ne; ns; vior patterns; and structural problems; ning and structural problems; is and health conditions; ional status;					
	protocols; and Documentation of	of participation in					
	record review, identify the lack comprehensive 3 residents revi	view, observation, and the facility failed to c of dentures on the assessment, for 1 of iewed for dental apple of 6 that met the lent #44)	F02'	72	F272 What corrective action(will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of the facility to assure that residents assessed appropriately in accordance with ability to eat a the presence or absence of	his are	07/16/2012

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Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155773			06/13/2012		2012
			B. WIN		ADDRESS OVEN STATE JID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
TEDD 4.0					CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					dentures. The correction action	n	
	Finding include	es:			taken for those residents found	d to	
	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				be affected by the alleged		
	During observe	ation on 6/5/12 at 9:07			deficient practice include:		
					Resident #44 no longer reside		
		#44 had only one			facility. How will other resident having the potential to be	nts	
		resent and no upper			affected by the same deficien	nt	
	teeth.				practice be identified and wh		
					corrective actions will be		
	During an inter	view on 6/5/12 at 9:07			taken? Other residents that ha	ave	
	a.m., Resident	#44 indicated he had			the potential to be affected will	-	
	upper dentures	s and a partial denture			identified by: All residents with		
		•			dentures/partial plates will be		
	plate for the bottom. Resident #44 indicated he did not wear his dentures				assessed to ensure they fit		
					properly and the resident has	no	
		s were too loose and			concerns with eating. These		
	1	onger. Resident #44			resident's will be care planned		
	indicated no or	ne at the facility had			dentures/partial plates. The M		
	asked him abo	ut his loose fitting			summaries have been updated reflect the appropriate oral	ט נט	
	dentures.				assessment. What measures		
					will be put into place or what		
	Resident #44's	record was reviewed			systemic changes will be ma		
	on 6/6/12 at 1:				to ensure that the deficient		
	011 0/0/12 at 1.	00 p.m.			practice does not recur? The	.	
	Decident #44	use admitted to the			measures or systematic chang	ges	
		vas admitted to the			that have been put into place t	ю.	
	1	2 and had a care plan			ensure that the alleged eficien	t	
	for nutrition rela	ated to his diabetes			practice does not recur include		
	mellitus, hyper	tension, and right			The MDS nurse and nursing s	taff	
	below the knee	e amputation. There			will be in-serviced and are	_	
	was no docum	entation in the dietary			responsible for assuring that the	ie	
		ocial service notes			assessments are correct and accurate to reflect the residet's	,	
		esident's loose fitting			condition during the assessme		
	dentures or ed				period including the use of	•	
	deniules of ea	entulous state.			dentures. The MDS Summary	,	
	The MESSIAN	Data Oad			Form has been updated to		
	_	imum Data Set]			include language directly from	the	
	· ·	ated 5/15/12, indicated			RAI Manual to ensure accurac	y.	
	the resident did	d not have any dental			How will the corrective action	n	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773		A. BUILDING	00	COMPI 06/13		
	PROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP CODI ICDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
IAU	issues. 3.1-31(c)(9)	ESC IDENTIFICION INTONIMATION)	IAU	be monitored to ensure in deficient practice willnow ie, what quality assurance program will be put into. The corrective action takes monitor performance to assurance is: A Performant Improvement Tool has be initiated that will be utilize review resident's assessmassure that they are correand accurately reflect the residents' conditions. The willrandomly review 5 resions The Director of Nursing, of designee, will complete the weekly x3, monthly x3, the quarterly x3. Any issues in will be immediately address the Quality Assurance Co will review the tools at the scheduled meeting following completion of the tool with recommendations as need. The date the systemic characteristics.	the t recur, ce place? In to sure y ice en dto nent to ct se tools dents. Ir e tools en dentified ssed. mmittee ing the inded. anges	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 06/13/2012			
		155773	B. WING		06/13/2012
	PROVIDER OR SUPPLIE		1701 N	ADDRESS, CITY, STATE, ZIP CODE MCDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY CARE PLAN The services pr facility must be in accordance v plan of care. Based on obse record review, ensure service accordance wi of 26 residents the plan of car did not receive Resident #138 dermasavers a plan of care. (I #138) Findings include 1. Resident # reviewed on 6. Resident #73 v 3/19/12 with a but not limited diabetes mellif currently recei Januvia, and of the treatment of A physician's of indicated Resi weighed daily, physician's or	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons with each resident's written ervation, interview, and the facility failed to es were provided in the plan of care for 2 areviewed for following e, in that, Resident #73 e a bedtime snack and did not have applied according to the Resident #73, Resident	F0282	F282 What corrective action will be accomplished for the residents found to have been affected by the deficient practice? Itis the practice of Solarbron to assure that all services that are provided are completed in a manner that is accordance with theplan of care those residents found tobe affected by the alleged deficie practice include: Resident#73 receives the bedtime snack are is offered replacements ifindicated. Resident#138 is having the dermasavers applic in accordance with the plan of care. How will other resident having the potential to be affected by the same deficies practice be identified and who corrective actions will be taken? Other residents that he the potential to be affected habeen identified by: All resident will be reviewed to assure that they are receiving services in accordance with the plan of care what systemic changes will be made toens that the deficient practice do not recur? The measures or systematic changes that have	in re. r mt md ed ets mare we tes t mare. mto ure pes

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPLE	ETED
		155773		LDING		06/13/2	2012
			B. WIN		ADDRESS OVEN STATE JID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
TEDD 4.0					CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	rolling walker,	and assistance of one			been put into place to ensure t	that	
	for ambulating.				the alleged deficient practice		
					does not recur include: An		
	Pasident #73 h	nad a care plan for			in-service will be conducted fo	r all	
		•			nursing staff related to the		
	nutrition, dated				importance of following the pla of care when providing service		
		esident had the			tothe residents. The in-service		
	1 '	eration in nutrition			includes providing the bedtime		
		nosis: congestive heart			snacks, replacement meals, if		
	failure, atrial file	orillation, hypertension,			indicated, and application of		
	diabetes mellit	us and the potential for			dermasavers inaccordance with	th	
		stipation due to the			the plan of care. The CNA		
		medications. The			assignments sheets have bee	n	
	1				reviewed to assure that they		
	1 -	l an intake of 75 -			accurately reflect the services		
		s, weight stable, labs			be provided to the residents in		
		imits, no signs or			correlation with the plan of car	e.	
	symptoms of e	dema, and no signs or			Nurses will be responsible for assuring that all services provi	idod	
	symptoms of s	wallowing or chewing			are completed in accordance		
	problems. The	interventions included			the care plans on their designation		
	the resident ha	id a mechanical soft			shifts via observation. Please		
	diet with aroun	d meat ordered, the			below for monitoring as part of		
	1	and fluid intake would			QA process. How will the		
		the resident would be			corrective action be monitor	ed	
	1				to ensure the deficient practi		
		ements between meals			willnot recur, ie, what quality	<i>'</i>	
	•	e Control 2 times a			assurance program will be p		
	day], the reside	ent's weight would be			into place? The corrective act		
	monitored wee	kly to ensure the			taken to monitor performance	to	
	resident had no	o significant weight			assure compliance through		
		esident's labs would be			quality assurance is: A Performance Improvement To		
	_	I the resident would be			has been initiated that random		
	· ·	HS [hour of sleep]			reviews 5 residents related to	,	
	snacks.	[oai oi oioop]			providing services in accordan	ice	
	SIIAUNS.				with theplans of care. The		
	Description in the contract of	0.740 -100			Director of Nursing, or designe		
	1	w, on 6/7/12 at 8:26			will complete this tool weekly		
	· ·	ndicated Resident #73			monthly x3, then quarterly x3.	Any	
	was fed at time	es and needed cueing			issues identified will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		1701 M	CDOWELL RD		
	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
IAG				TAG	•		DATE
TAG	when she fed has snack, except of 5/16/12, 5/21/1 The Hydration/indicated the real snack at 8:00 through 6/5/12. The Food Intak 2012, and May Resident #73 or replacement or food she did not literview with the dietician, on 6/2 indicated the real snack checklist resident's bask The R.D. indicated snack consumptions.	checklist indicated the of received a HS on 4/11/12, 4/13/12, 2, and 6/4/12. Snack Tracker esident was not offered of p.m. from 6/1/12 of the Record, dated April of 2012, indicated did not receive a resupplement for the of eat. The R.D. [registered /8/12 at 9:15 a.m., esident had a basket for room and the HS of the only indicated the feet was replenished. The attention of residents.		TAG	immediately corrected. The Quality Assurance Committee review the tools at the schedul meetings with recommendatio as needed. The date the systemic changes will be completed: 7-16-12	will ed	DATE
		a.m., she indicated she					
		reach the basket on					
		er snack. She indicated					
		ould give her snacks					
	from the baske	t when she came to					
	visit, but her da	aughter did not visit her					
	at bedtime and	her hours of visitation					
	varied accordir	ng to her work					
		also indicated she did					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIEF	· ·		1701 M	CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	not receive a s						
	replacement to	r uneaten meals.					
	2. On 6/5/12 a	it 2:50 p.m., Resident					
	#138 was obse	erved in a wheelchair in					
	her room. She	had short sleeves on.					
	A two centimet	er bruise was observed					
	on her left arm	•					
	Resident #138	's clinical record was					
	reviewed on 6/	6/12 at 1:40 p.m.					
	Diagnoses incl	uded, but were not					
	limited to, dem	entia, coronary artery					
	disease, Parkir	nson's disease,					
	diabetes mellit	us, and hypertension.					
		•					
	A care plan da	ted 5/18/12, for being					
	at risk for abno	ormal bleeding or					
		ecause of anticoagulant					
	usage included	d, but was not limited					
	to, the following						
		report to nurse any of					
		gns and symptoms of					
	bleeding:	• , ,					
	-bleeding gums	S					
	-nose bleeds						
	-unusual bruisi	ng					
	-tarry, black sto	•					
	-pink or discolo						
	A care plan da	ted 5/18/12, for being					
	•	loping complications					
		needing total assistance					
		Daily Living included,					
		nited to, the following:					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	/2012
NAME OF F	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	-Broda chair fo	R LSC IDENTIFYING INFORMATION)		TAG	32.102.101		DATE
	-active ROW [1	ange of motion] BU					
	-	ן מות ב נוטשפון nelp with stiffness					
		s [sleeve like padded					
		s] to BUE [bilateral					
		ies] when out of bed to					
	protect skin.	which out of bod to					
	protoot okini						
	Physician's ord	ders dated 5/17/12,					
	1	ders for "May use sit to					
		[as needed] for					
		"Derma Savers to bil.					
		o protect skin when					
	OOB [out of be	•					
	-	-					
	Resident #138	was observed on					
	6/6/12 at 1:15	p.m., up in the Broda					
	chair. She con	nplained of being cold.					
	She was weari	ng short sleeves with					
	no Derma Sav	ers.					
		25 p.m., CNAs #1 and					
		ved to use a gait belt					
		esident #138 to the					
		dent had long pants					
	·	shoes. She was					
		t bear much weight.					
	According to the						
		better. Some bruising					
		on the right rear calf					
	and side of the	leg.					
	0= 0/7/40 = 4.0						
		:17 a.m., the resident					
	was observed	in the exercise room					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	
		155773	B. WIN			06/13/	2012
NAME OF F	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE		
TERRAC	E AT SOLARBRON	N THE			CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	passively obsewearing 3/4 ler pants. No Derrobserved. On Savers were of behind the toile bathroom. On 6/7/12 at 10 was observed activity, sensor a lightweight jaund on 6/7/12 at 4: was observed skirt on. No Deobserved on the She did have the legs. On 6/8/12 at 10 was observed short sleeves opicking at her of Savers were on	rving. She was agth sleeves and capris ma Savers were 9:21 a.m., the Derma beserved on a shelf et in the resident's 0:35 a.m., the resident in a small group by stimulation. She had					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			CDOWELL RD		
TERRAC	E AT SOLARBRON	I THE			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident m must provide the services to attain practicable phys psychosocial we the comprehensi care. Based on obse record review, ensure 1 of 3 re skin conditions who met the cri conditions, rece treatment and s further bruising the plan of care sleeves were n #138)	E/SERVICES FOR HIGHEST ust receive and the facility encessary care and or maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of extraction, interview and the facility failed to esidents reviewed for in the sample of 3 iteria for review of skin eved appropriate services to prevent in accordance with e, in that protective ot used. (Resident	F03	TAG	F309 What corrective action(will be accomplished for thoo residents found to have been affected by the deficient practice? It is the practice of facility to assure that all reside receive the necessary care an services to attain or maintain thighest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment. To correction action taken for thoo residents found tobe affected if the alleged deficient practice	(s) se this ents d he the	DATE 07/16/2012
	Finding include				include: Resident#138 now hat protective sleeves in place in		
		50 p.m., Resident rved in a wheelchair in			accordance with the plan of ca How will otherresidents havi		
		had short sleeves on.			the potential to be affected b	-	
					the same deficientpractice be	-	
		er bruise was observed			identified and what correctiv		
	on her left arm.				actions will be taken? Other		
					residents that have the potenti		
		s clinical record was			to be affected will be identified		
	reviewed on 6/0	6/12 at 1:40 p.m.			All residents will be reviewed t assure that they are receiving	U	
	Diagnoses incl	uded, but were not			service sin accordance with th	e	
	limited to, demo	entia, coronary artery			plan of care including but not	-	
	disease, Parkir	nson's disease,			limited to protective sleeves.		
		us, and hypertension.			What measures will be put in	ito	
		, - · · · · · · · · · · · · · · · ·			place or what systemic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVE	ΣY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPLETED	
		155773	A. BUII			06/13/2012	
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	1		l	ADDRESS, CITY, STATE, ZIP CODE		
TEDD 4.0					CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					changes will be made to]	
	A care plan dat	ted 5/18/12, for being			ensure that the deficient		
	•	rmal bleeding or			practice does not recur? The	•	
		ecause of anticoagulant			measures or systematic chang		
	_	•			that have been put into place t		
	_	l, but was not limited			ensure that the alleged deficie		
	to, the following	-			practice does not recur include		
	Monitor for and	report to nurse any of			An in-service will be conducted for all pursing staff related to the		
	the following si	gns and symptoms of			for all nursing staff related to the importance of following the plate.		
	bleeding:				of care when providing service		
	-bleeding gums				to the residents. The in-service		
	-nose bleeds				will include application of		
		na			protective sleeves in accordan	ce	
	-unusual bruisi	•			with the plan of care. The CNA		
	-tarry, black sto				assignment sheets have been		
	-pink or discolo	ored urine			reviewed to assure that they		
					accurately reflect the services	to	
	A care plan dat	ted 5/18/12, for being			be provided to the residents in		
	at risk for deve	loping complications			correlation with the plan of car	e.	
		eeding total assistance			Nurses will be responsible for		
		Daily Living included,			assuring that all services provi are completed in accordance v		
		ited to, the following:			the care plans on their designation		
		_			shifts via observation. Please		
	-Broda chair fo				below for monitoring as part of		
	_	ange of motion] BU			the QA process. How will the		
	[bilateral upper] and L [lower]			corrective action be monitor	ed	
	extremities to h	elp with stiffness			to ensure the deficient practi	ce	
	-Derma Savers	[sleeve like padded			willnot recur, ie, what quality		
	covers for arms	s] to BUE [bilateral			assurance program will be p	ut	
		es] when out of bed to			into place? The corrective		
	protect skin.				action taken to monitor		
	protoot akin.				performance to assure		
	Dhyaiais sta	lore dated E/17/40			compliance through quality		
	-	ers dated 5/17/12,			assurance is: A Performance Improvement Tool has been		
		ders for "May use sit to			initiated that will be utilized to		
	stand lift PRN [as needed] for			observe for the provision of		
	transfers," and	"Derma Savers to bil.			services in accordance with th	e	
	UE as a D.M. to	o protect skin when			plan of care. The tool will	-	
	OOB [out of be	•	1		randomly review 5 residents to		

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AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE INTERPRETIX (124) IID SUMMARY STATEMENT OF DEFICIENCIES (124) IID REFEIX (125 p.m., Up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	DING	00	COMPLE	TED
TERRACE AT SOLARBRON THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were			155773				06/13/2	2012
TERRACE AT SOLARBRON THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX FAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were				B. WIIN		ADDRESS CITY STATE ZIP CODE		
TERRACE AT SOLARBRON THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were	NAME OF F	PROVIDER OR SUPPLIER			1			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	TEDDAO	E AT COL ADDDON						
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was wearing 3/4 length sleeves and capris pants. No Derma Savers were	TERRAC	E AT SOLARBRON	ITHE		EVANS	VILLE, IN 47712		
Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was wearing 3/4 length sleeves and capris pants. No Derma Savers were	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'-	DATE
Savers were observed on a shelf behind the toilet in the resident's bathroom. On 6/7/12 at 10:35 a.m., the resident was observed in a small group activity, sensory stimulation. She had a lightweight jacket on.		Resident #138 6-6-12 at 1:15 pchair. She come she was wearing no Derma Save on 6-6-12 at 1: #2 were observed and transfer Resident. The resident, socks and sobserved to now According to the sometime did be was observed in passively observed in passively observed. On 6-7-12 at 9: was observed in passively observed. On 6-7-12 at 9: was observed in passively observed. On 6-7-12 at 9: was observed in pants. No Dermobserved. On 6-7-12 at 10 was observed in activity, sensor a lightweight ja 0n 6/7/12 at 4:	was observed on p.m., up in the Broda aplained of being cold. In a short sleeves with ers. 25 p.m., CNAs #1 and wed to use a gait belt esident #138 to the dent had long pants shoes. She was to bear much weight. It is come bruising on the right rear calfuleg. 17 a.m., the resident in the exercise room right sleeves and caprisma Savers were 19:21 a.m., the Derma observed on a shelf et in the resident in a small group y stimulation. She had ocket on. 15 p.m., the resident			assure that the residents are receiving the services as identified. The Directorof Nursi or designee, will complete this audit weekly x3, monthlyx3, the quarterly x3. Any issue identific will be immediatelycorrected. Quality Assurance Committee review the tool at the schedule meeting following the completi of the tool with recommendation as needed. The date the systemic changes will be	ing, en ed The will ed on	
			15 p.m., the resident seated in lobby with					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155773	A. BUILDING B. WING	00	COMPI 06/13	LETED
	PROVIDER OR SUPPLIER E AT SOLARBRON THE	1701 M	ADDRESS, CITY, STATE, ZIP CODE COOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	skirt on. No Derma Savers were observed on the upper extremities. She did have the Derma Savers on her legs. On 6/8/12 at 10:50 a.m., the resident was observed lying in bed. She had short sleeves on and was observed picking at her coverings. No Derma Savers were on her arms. Derma Savers were observed on her legs. 3.1-37(a)	TAG	DEFICIENCY)		DATE

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED	
		155773	B. WING			06/13/	06/13/2012	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					CDOWELL RD			
TERRAC	E AT SOLARBRON	ITHE		EVANS	VILLE, IN 47712			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
TAG F0325 SS=D	483.25(i) MAINTAIN NUTE UNAVOIDABLE Based on a resident - (1) Maintains acconstraint levels, ure condition demone possible; and (2) Receives a treat nutritional probectors are cord review, the ensure 2 of 3 resignificant weight of nutrition, receives treatment and see weight loss, in the were not provided the second review. Findings including the second review of	rvation, interview, and the facility failed to esidents reviewed for the loss in the sample the criteria for review eived appropriate services to prevent that evening snacks led. (Resident #31,	F032	TAG 25	F325 What corrective action(will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of Solarbron to assure that each resident identified as having significant weight loss have appropriate treatment and services in place to assist with preventing further weight loss. The correction action taken for those residents found to be affected by the alleged deficien practice include: Resident#31 now has orders for nutritional supplements to assist in the	s) see	DATE 07/16/2012	
		6/12 at 2:45 p.m.			prevention of further weight los Resident#73 is receiving	SS.		
		vas admitted with			nutritional supplements as			
	-	out not limited to, and diabetes mellitus.			ordered. This resident isalso			
	,	vas currently receiving			receiving replacements for			
	Lantus insulin,	·			uneaten meals. Snacks are availablewithin her reach. <i>How</i>	,		
		nich are used for the			will other residents having th			
	treatment of dia				potential to be affected by th			
	a caunoni oi die	azeta momua.			same deficient practice be			
	A physician's o	rder dated 4/6/12			identified and what corrective actions will be taken? Other	е		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155773	B. WIN			06/13/	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			CDOWELL RD			
TERRAC	E AT SOLARBRON	J THE			VILLE, IN 47712			
					VICEE, IIV 17712			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		-1	DATE	
		dent #73 was to be			residents that have the potenti to be affected have been	aı		
		Resident #73 had a			identified by: All residents will	he		
	1	er indicating the			reviewed to assure that if need			
	resident was to	be up with a gait belt,			they are receiving nutritional	,		
	rolling walker, a	and assistance of one			supplements to assist with the			
	for ambulating.				prevention of weight loss in			
					accordance with the physician			
	Resident #73 h	nad a care plan for			orders. What measures will b			
	nutrition, dated	•			put into place or what system	nıc		
	indicated the re	•			changes will be made to ensure that the deficient			
		eration in nutrition			practice does not recur? The	1		
	•				measures or systematic change			
	_	nosis: congestive heart			that have been put into place t			
		orillation, hypertension,			ensure that the alleged deficie			
		us, and the potential for			practice does not recur include			
	increased cons	stipation due to the			Nursing staff will be in-serviced			
	number of pain	medications. The			related to assuring that nutritio			
	goals indicated	l an intake of 75 -			supplements, replacements fo	r		
	100% for meals	s. weight stable , labs			uneaten meals, and bedtime snacks are offered in accordar	200		
	within normal li	mits, no signs or			with the plan of care and/or	icc		
		dema, and no signs or			physician'sorders. The nurses	will		
	1 7 '	wallowing or chewing			be in-serviced related to			
		interventions included			identifying weight loss in a time	ely		
	•	d a mechanical soft			manner and assuring that the			
		d meat ordered, the			physician is notified for any			
	, ,	,			recommendations. The			
		and fluid intake would			interdisciplinary team will be reviewing weights weekly to			
	· ·	the resident would be			assure that all residents showi	na		
		ements between meals			significant weight loss have	9		
	_	e Control 2 times a			appropriate interventions in pla	ace.		
		ent's weight would be			In addition, the Dietician will be			
	monitored wee	kly to ensure the			providing nursing administration			
	resident had no	significant weight			list of recommendations so that			
	changes, the re	esident's labs would be			appropriate follow-up is assure			
	_	I the resident would be			How will the corrective action be monitored to ensure the	11		
	•	HS [hour of sleep]			deficient practice will not red	eur.		
	snacks.	[da. d. d.ddp]			ie, what quality assurance	·ui,		
	Juliacka.		1					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155773	1	LDING		06/13/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
TEDDAG		LTUE			CDOWELL RD		
TERRAC	CE AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	During interview CNA #73 indicated Resident weigh On 4/11/12, the Note indicated	w 6/7/12 at 8:26 a.m., ated Resident #73 was d needed cueing when file. Progress Note, dated p.m., indicated had no swallowing or lity and consumed 50 - heals daily. Progress Note, dated to p.m., indicated the ed Boost Glucose is a day but had been een note also indicated its in the dining room mechanical soft diet eat due to loose fitting. Progress Notes the DoN [Director of 8/12 at 10:52 a.m.,		TAG	program will be put into place. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviresidents who have been identifed with significant weightloss/gain. This tool will randomly review 5 residents. TheRegistered Dietician, or designee, will complete the too weekly x3,monthly x3, then quarterly x3. Any issues identified will beimmediately addressed. The Quality Assurance Committee will reviewthe tool with the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic change will be completed: July16, 20	e? ews ol fied at	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155773	B. WING		06/13/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		1CDOWELL RD	
TERRAC	E AT SOLARBRO	N THE		SVILLE, IN 47712	
	1			,	(115)
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION DATE
IAG		<u> </u>	IAG		DATE
		of 120 - 480 ml [milliliter]			
	for meals.				
		ll Progress Note			
	indicated on 4	/12/12 at 4:00 p.m., the			
	resident's diet	was changed to a			
	mechanical so	oft, and the resident's			
	care plan was	updated.			
	On 4/18/12 at	1:45 p.m., the			
		ogress Note indicated			
		ad a decline from 4/6/12			
		onal Therapy was			
		nodified utensils and			
		e Control 2 times a day			
	was ordered.				
	0 1/20/12 04	1.21 +			
		1:31 p.m., the			
		gress Note indicated			
		eeded cueing, her tray			
		couragement for meals.			
	Her weight on	4/19/12 was 105.4			
	pounds with a	4.4 pound weight loss			
	and a new ord	ler for Boost Glucose			
	Control 2 time	s a day was ordered.			
	The Nutritiona	Il Progress Note from			
		ed the resident ate in			
	her room and	was a slow eater. The			
		the resident had no			
		swallowing or chewing			
	! ·	ntake was 50 - 100% at			
		ote indicated the			
		(0 - 50% and her			
	weight was sta	able at 105.4 pounds.			
	1		1		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155773	B. WIN			06/13/	2012
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
TERRAC	E AT SOLARBRON	N THE			CDOWELL RD VILLE, IN 47712		
					VILLE, IIV 17712		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	The Nutritional	Progress Note, dated					
		0 p.m., indicated					
Resident #73 weight was 99 pounds							
		nd weight loss in the					
	-	The note indicated					
	Resident #73 v	vas refusing her Boost					
		ol 2 times a day. The					
		the dietician would					
	contact the res	ident's family for					
	wishes for the	resident. The note					
	indicated the re	esident's intake was fair					
	and the resider	nt was eating in the					
	dining room.						
		nad a BMP [Basal					
		ile] on 5/11/12 which					
		od glucose of 163					
	_	en 70 -99], a BUN					
	_	trogen] of 21 [normal					
	_	, and a CO2 [Carbon					
	-	of 35 [normal levels					
		3]. Resident #73's					
		l indicated a glucose of					
	113.						
	The HS Snack	checklist indicated the					
		ot received a HS snack					
		/12, 4/13/12, 5/16/12,					
	-						
	,						
	,						
		•					
	_						
		·					
	5/21/12, and 6/ The Hydration/ indicated the re a snack at 8:00 through 6/5/12 The Food Intak	/4/12. Snack Tracker esident was not offered) p.m. from 6/1/12					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155773	A. BUILDING	3	00	06/13/	
		100770	B. WING	DEEM :	DDDEGG CITY OT TO COPE	00/13/	2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
TERRAC	E AT SOLARBRON	ITHE			VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		id not receive a	IA	G	BH ICH. C. I		DATE
		supplement for the					
	food she had n						
	1000 SHE Had II	or are					
	During interviev	w with the R D					
	_	ician], on 6/8/12 at					
	- -	R.D. indicated the					
	•	basket of snacks in					
		ne HS Snack checklist					
		he resident's basket is					
	•	he R.D. indicated she					
	· •	ack consumption of					
	residents.						
	During interviev	w on 6/8/12 at 9:30					
	_	#73 indicated she was					
	unable to reach	the basket on her					
	table for her sn	ack. She indicated her					
	daughter would	I give her snacks from					
	the basket whe	n she came to visit but					
	her daughter di	d not visit her at					
	bedtime and he	er hours of visitation					
	varied accordin	g to her work					
	schedule. She	also indicated she did					
	not receive a si	upplement or					
	replacement fo	r uneaten meals.					
	2. Resident #3	1's clinical record was					
	reviewed on 6/6	6/12 at 2:45 p.m. The					
	record indicated	d the resident was					
	re-admitted on	5/11/12. Diagnoses					
	included, but w	ere not limited to,					
	general debility	, status/post valve					
		coumadin [blood					
	•	retention, congestive					
	· ·	pertension, chronic					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	ſ ´	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
		155773	B. WING			3/2012
NAME OF I	PROVIDER OR SUPPLIEI	R		ET ADDRESS, CITY, STATE,	ZIP CODE	
TEDDAC	E AT SOLARBRON	N THE		1 MCDOWELL RD NSVILLE, IN 47712		
				1105 VILLE, IIV 477 12		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE AC		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
		mia, pneumonia,				
	•	d heart disease.				
	,					
Physician's orders, signed 5/29/12,						
indicated the resident was on a						
regular diet as of 5/16/12.						
	•	ech Therapy for				
		ation and treatment				
	were obtained	on 5/22/12.				
	The care plan	for alteration in				
	•	us, dated 5/15/12,				
		vas not limited to, the				
	following:	rao not minioa to, tho				
	-regular diet 5/	16/12				
	-monitor food/f					
	-monitor weigh	t daily/? to ensure no				
	significant weig	ght changes				
	-visit resident t	o determine				
	likes/dislikes					
	-provide select	menu for food				
	preferences					
	On 6/7/40 =1.44	0.00				
	On 6/7/12 at 12	•				
		h tray was observed on ble, covered. A				
		nician was drawing				
	1	eech Therapist entered				
	·	was interviewed on				
		2 p.m. She indicated				
		the resident for				
		first, but discontinued				
		as swallowing well and				
		ng him for cognitive				

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Event ID: OZJH11

Facility ID: 010930

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/42/2042
		155773	B. WING		06/13/2012
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COE MCDOWELL RD	DE
	E AT SOLARBRON		EVAN	ISVILLE, IN 47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT OF A CTION SHOW	
	`			CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE
PREFIX TAG	improvement. just checking of because he has slurring that moderned. Dietitian notes p.m. indicated to "Resident's wto libs [down] 15 lid diet with intake On Lasix [diure QD (has been stored [ldeal Body Wew Will have nursin MD." 6/4/12 1047 [10 191.2 lbs [up] 10	She indicated she was in him that day did a spell where he was brining and she was a spell where was and notify brining assess and notify brining assess and notify brining assess and indication was notified or nursing brining and his weight was brining and his weight	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	TION ILD BE COMPLETION
ı	-	a.m., indicated.			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
			5. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		6/6/12 186.2 lbs					
		X 1 wk, [down] 22.2 lbs					
	_	nission]. Will request					
	med pass [nutr	ritional supplement] 90					
	cc [cubic centir	meters] TID [three					
	times a day] d/	t [due to] wt. loss.					
		ntakes generally					
	50-100% of me	eals."					
		0:00 a.m., LPN #2 was					
		he indicated when the					
	dietitian made	recommendations, she					
	often faxed the	m herself to the					
	physician. She	e reviewed the record					
	to see if the ph	ysician had been					
	notified on 5/3°	1/12 about the					
	resident's weig	ht loss. She reviewed					
	a folder with fa	xes in it. She indicated					
	he was not eat	ing well when he first					
	got to the facili	ty and had a lot of fluid					
	taken off during	g his last					
	hospitalization,	prior to admission.					
	She further ind	icated she usually					
		gs, so notification of					
		vas not always passed					
	on.	, ,					
	On 6/8/12 at 10	0:10 a.m the					
		titian was interviewed					
		she reviewed the					
		eek and wrote the note					
		sing to assess the					
		otify the physician.					
		she was then off work.					
	ı one re-evaluat	ed him this week and					l

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Event ID: OZJH11

Facility ID: 010930

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PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/13	LETED
	PROVIDER OR SUPPLIER		<u> </u>	1701 M	DDRESS, CITY, STATE, ZIP CODE CDOWELL RD VILLE, IN 47712	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	recommended supplement dur loss. She indice #1, the nurse the said she had a and would also supplement for doctor called be time revealed in the physician be weight loss. He a change in be	the resident when the ack. Review at the lo documentation of eing notified of the le had been notified of havior and had abwork. No orders for					

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Event ID: OZJH11

Facility ID: 010930

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155773	A. BUII B. WIN			06/13/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CDOWELL RD		
TERRAC	E AT SOLARBRON	I THE			VILLE, IN 47712		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329 SS=D	483.25(I) DRUG REGIMEI UNNECESSARY Each resident's of from unnecessary drug is any drug dose (including of excessive duration monitoring; or with for its use; or in the consequences with should be reduced combinations of the state of the use of a slet that the medical documentation alternatives atternatives atternat	N IS FREE FROM DRUGS drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate thout adequate indications the presence of adverse rhich indicate the dose and or discontinued; or any the reasons above. prehensive assessment of a dity must ensure that ave not used antipsychotic ren these drugs unless and therapy is necessary to condition as diagnosed and the clinical record; and the antipsychotic drugs dose reductions, and the entions, unless clinically in an effort to discontinue and review and the accility failed to ensure the reviewed for the dications had the use and follow-up on the person without	F03	TAG	F329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this facility to assure that residents are assessed appropriately related to psychoactive medication usage. The correction action taken for those residents found to be	(s) se f	
	Finding include	,			affected by the alleged deficient practice include: Resident #13 no longer resides at the facility How will other residents have the potential to be affected by	37 '. ing	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	BUILDING COMPLETE.			ETED
		155773	B. WIN			06/13/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CDOWELL RD		
TEDDAC	E AT SOLARBRON	J THE			VILLE, IN 47712		
TERRAC	E AT SOLARBROI	N IIIE		EVAINS	VILLE, IN 477 12		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident #137	's clinical record was			the same deficient practice b		
	reviewed on 6/6/12 at 4:07 p.m. The resident's diagnoses included, but				identified and what correctiv		
					actions will be taken? Other		
	_	d to, atrial fibrillation,			residents that have the potenti	iai	
		status, arthritis,			to be affected have been identified by: All residents that		
		and thyroid disease.			receive sleep medications will		
	i ilaherrengini	and myrold disease.			reviewed to assure that	~~	
	The same 11 11	and a desiration			alternative interventions are		
	The resident ha				attempted and unsuccessful p	rior	
		lers, dated 5/25/12, for			to using. All residents will be		
	Tylenol PM 25-500 milligrams one by				reviewed that receive PRN pa	in	
	mouth at bedtime as needed for				medications to assure that pro	-	
	insomnia.				documentation is present on the	ne	
					back of the MAR and or Pain		
	The Medication	n Administration			Tracking Form to substantiate		
		y, 2012 indicated the			reason for the administration of the medication. What measure		
					will be put into place or what		
	1 -	s given on 5/27/12,			systemic changes will be ma		
	•	/30/12. There was no			toensure that the deficient		
		of the reason for the			practice does not recur? The	e	
	medication or t	the effect. The nurses'			measures or systematic chang		
	notes were rev	iewed and failed to			that have been put into place t	:0	
	indicate the rea	ason, any other			ensure that the alleged deficient		
		or the effect of the			practice does not recur include		
	medication.				Nurseswill be in-serviced relat	٠ ١	
					to proper documentation relate		
	During interview	ith DN #4 an			to medication administration.	ine	
		w with RN #1, on			in-service will include informationrelated to PRN slee	an	
		.m., she indicated "if			medications and PRN pain	- ρ	
		eeded medications],			medication. How will the		
	should write or	n the back [of the			corrective action be monitor	ed	
	Medication Adı	ministration Record]			to ensure the deficient practi		
	why and wheth	ner or not they were			will not recur, ie, what qualit		
	effective."	•			assurance program will be p		
					into place? The corrective act	tion	
	3.1-48(a)(6)				taken to monitor performance	to	
	0.1-40(a)(0)				assure compliance through		
					quality assurance is: A	.	
					Performance Improvement too	ol	

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PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155773	A. BUILDING B. WING		COMPLETED - 06/13/2012	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
TERRAC	E AT SOLARBRON	I THE		CDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				has been established that randomly reviews residents will have orders for PRN sleep and pain medications to assure that they are documented properly accordance with the guideline. This tool will randomly review residents. The Director of Nursing, or designee, will complete the tool weekly x3, monthlyx3, then quarterly x3. vissues identified will be immediately addressed. The Quality Assurance Committee review the tool atthe schedule meeting following the completion of the tool with recommendation as needed. The date the systemic changes will be completed: July16, 2012	d at in s. 5 Any will d ion	

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Event ID: OZJH11

Facility ID: 010930

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CDOWELL RD		
TERRAC	E AT SOLARBRON	ITHE	EVANSVILLE, IN 47712				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.35(d)(1)-(2) NUTRITIVE VAL PALATABLE/PR Each resident re provides food proconserve nutritive appearance; and attractive, and attractive, and attractive, and attractive, and attractive, resure 9 of 11 food quality, in met the criteria quality, receive temperature. (#143, #144, #1#149) Findings include	LISC IDENTIFYING INFORMATION) LUE/APPEAR, EFER TEMP ceives and the facility epared by methods that e value, flavor, and if food that is palatable, the proper temperature. rvation, interview, and the facility failed to residents reviewed for the sample of 25 who for review of food d food at a palatable Resident #44, #142, 45, #146, #147, #148,	F03	TAG	F364 What corrective action will be accomplished for thoresidents found to have been affected by the deficient practice? It is the practice of facility to assure that all meals served to residents within appropriate temperature guidelines. The corrective act taken for those residents found be affected by the alleged deficient practice include: Resident#44 no longer resides the facility. Residents# 142, #7 #145, #146, #147, #148, and #149 are receiving all meals a	(s) se 1 this are ion d to	
	8:35 a.m., Resi	dent #143 indicated			appropriate temperatures. Ho will other residents having the	ne	
		as sometimes cold			potential to be affected by th	е	
	when she got it				same deficient practice be identified and what corrective	Δ .	
	seasoned to he	er liking.			actions will be taken? Other		
					residents that have the potenti		
	During an inter	view on 6/5/12 at 9:37			to be affected have been		
	_	#144 indicated the hot			identified by: Because of the		
	food was some				systems that have been		
					implemented, all residents are		
	During an inter	view on 6/5/12 at			receiving meals at the appropr		
	_	sident #142 indicated			temperatures. What measure		
					will be put into place or what		
	-	e of the hot food was			systemic changes will be ma to ensure that the deficient	ue	
	not hot enough				practice does not recur? The	ے ا	
					measures or systematic chance		

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Event ID: OZJH11

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, pull phic	00	COMPLETED
		155773	A. BUILDING		06/13/2012
			B. WING	EET ADDRESS CITY STATE ZIR CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		EET ADDRESS, CITY, STATE, ZIP CODE	
TEDDAG		U TUE		1 MCDOWELL RD	
TERRAC	E AT SOLARBRON	NIHE	EV	ANSVILLE, IN 47712	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		5.112
	During an inter	view on 6/8/12 at 8:02		that have been put into place	
	a.m., Resident	#145 indicated the		ensure that the deficient prac	tice
	food on his bre	akfast tray was edible		does not recur include: The	ud to
		dent #145 indicated it		dietary staff will be in-service reiterate the practice of takin	
		days, but his wife was		temperatures of the food price	_
		with him during meal		serving the food in accordan	
		would heat the food in		with the facility policy. Nursin	
				staff will be in-serviced relate	
	the microwave	IOI IIIIII.		assuring that there is timely	
				delivery of meals service to	
	An observation	was made on 6/8/12		assure that food remains at	
	at 7:49 a.m. of	meal trays being		appropriate temperatures at	
	delivered to res	sident rooms on the		time. Please refer to monitor	_
	east hall, at 7:5	56 a.m. When the last		systems to assure compliant	
		ered to the last resident		with food temperatures include resident interviews. How wi	_
	1	II, the test tray was		corrective action be monitor	
		-		to ensure the deficient prac	
		the tray cart and the		will not recur, ie, what quali	
	•	of the foods were taken		assurance program will be	- I
	and documente			into place? The corrective	
		s 94.8 degrees, milk in		action taken to monitor	
	the carton 54.3	degrees, orange juice		performance to assure	
	in a glass 53.4	l degrees, and bacon		compliance through quality	
	cold to the touc	ch.		assurance is: A Performance	e
				Improvement tool has been	
	A document ti	tled Dining Atmosphere		established that randomly re	
		0, provided by the		food temperatures. This tool	
		•		randomly review test tray sail verify that temperature logs a	
	_	tician, indicated it was		complete. The tool will also	116
		licy to serve hot food		interview residents to assure	that
		od cold "as acceptable		the food is being served at	
	to the individua	al being served."		appropriate temperature. The)
				Dietary Manager, or designe	e, will
				complete the tool weekly x3,	
				monthly x3, then quarterly x3	5. Any
				issues identified will be	
				immediately addressed. The	
				QualityAssurance Committee	
				review the tool at the schedu	iea

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155773	B. WIN			06/13/2	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1701 M	CDOWELL RD		
TERRAC	E AT SOLARBRON	I THE			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ĪΕ	DATE
	2. Resident #4 6/5/12 at 9:07 a could be warma On interview or Resident #44 i warm and good was usually not interview with F at 12:00 p.m., h receive ketchup but his food wa indicated his fo enough when h Interview with F 6/5/12 at 9:46 a ate her meals in dining room and enough. She in usually had to r microwave ove On interview or Resident #44 in	4 was interviewed on a.m. indicated the food er. 1 6/5/12 at 12:15 p.m., ndicated lunch was don that day but this the case. On Resident #44 on 6/7/12 ne indicated he did not of for his french fries is hot. The resident od is usually not warm he receives it. Resident #149 on a.m. she indicated she in the rehabilitation do her food is not hot indicated the staff reheat her food in the in. 1 6/5/12 at 10:04 a.m., indicated she ate in the			CROSS-REFERENCED TO THE APPROPRIAT	on	
	too cool when s 3. During confi Resident #146	d her food is usually she receives it. Idential interview with on 6/5/12, the resident ing this far down [the					

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Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155773	B. WIN			06/13/	2012
NAME OF P	PROVIDER OR SUPPLIEF	?	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	<u>-</u>	n is melted and the					
	meat's not war	m enough."					
	_	ntial interview with					
		on 6/5/12, the resident					
		was not always warm					
	when she rece	ived it.					
	District of the second of the	atial internal according					
	_	ntial interview with					
		on 6/5/12, the resident					
		ood was not always					
	hot.						
	On 6/7/40 at 4	1.11 1.15 - 5 - 5 - 5					
		1:41 a.m., lunch trays					
		being passed on the					
		a.m., when all the					
	_	passed, a test tray					
		food temperatures.					
	_	eese measured 58					
	degrees.						
	2.4.24/=\/0\						
	3.1-21(a)(2)						

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Event ID: OZJH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155773	B. WING			06/13/	2012
			B. WITE		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CDOWELL RD		
TERRAC	E AT SOLARBRON	I THE			VILLE, IN 47712		
					VILLE, IIV 477 12		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0431 SS=D	& BIOLOGICALS The facility must services of a lice establishes a system and disposition of sufficient detail to reconciliation; and records are in or controlled drugs periodically reconciliation. Drugs and biological be labeled in accepted profess the appropriate a instructions, and applicable. In accordance we the facility must see biologicals in loc proper temperature.	DS, LABEL/STORE DRUGS Seemploy or obtain the ensed pharmacist who stem of records of receipt of all controlled drugs in the enable an accurate and determines that drug der and that an account of all is maintained and					
	permanently affire storage of control II of the Comprel Prevention and Compressive to facility uses sing distribution systems stored is minimal readily detected.		F043	2.1			07/16/2012
	record review, tensure medicate	rvation, interview and the facility failed to tions were stored i-dose medication	1.043) <u>1</u>	F431 What corrective action(will be accomplished for thos residents found to have been affected by the deficient practice? It is the practice of	se	07/10/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILI DIDIC	00	COMPLETED
		155773	A. BUILDING		06/13/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R			
TEDDAC	E AT SOLARBRO	N THE		ICDOWELL RD SVILLE, IN 47712	
TERRAC	E AT SOLARBROI	N THE	EVAINS	SVILLE, IN 477 12	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	containers wer	e disposed of timely,		Solarbron to assure that all dr	rugs
	for 3 of 27 stag	ge 2 sample residents,		and biologicals are secure	
	in that medicat	ions were in sight in		appropriately and disposed of	
		nd eye drops were		when expired. The correction action taken for those residen	te
		ept beyond 30 days.		found to be affected by the	15
		pr beyond oo days.		alleged deficient practice inclu	ıde.
	Findings include:			Resident #135 has medication	
	Findings includ	ie:		stored securely. Resident #13	
				has medication stored secure	
		135's room was		Resident #73 eye drops that h	
	observed on 6	/4/12 at 9:05 a.m. A		expired have been disposed of	of
	bottle of Patad	ay [medication for eye		properly. How will other	
	itching related to allergies] eye drops			residents having the potenti	al
	_	at the bedside on a		to be affected by the same	
	table.			deficient practice be identifi	ed
	tabic.			and what corrective actions	
	0 Daaidant#	1071		will be taken? Other resident that have the potential to be	5
		137's room was		affected have been identified	hv:
		-5-12 at 9:35 a.m. A		All residents have the potentia	-
	bottle of Gente	el [lubricant eye		be affected. The nurses will be	
	medication] ey	e drops was observed		in-serviced to assure that	
	on the table be	eside the resident's		medications are secure and	
	chair. She ind	icated she used them		disposed of properly when	
	four times a da	N		expired. Please refer to system	
		.,		below and means of monitoring	_
	3 The Fact II	nit medication cart was		What measures will be put in	nto
				place or what systemic	
		/7/12 at 3:00 p.m.		changes will be made to ensure that the deficient	
		nad Lumigan [used to		practice does not recur? The	_
	_	a] eye drops dated as		measures or systematic change	
	opened on 4/2	8/12. The same		that have been put into place	
	resident had C	ombigan eye drops [for		ensure that the alleged deficie	
	glaucoma], dat	ted as opened on		practice does not recur includ	
	_	#2 indicated, during		The nurses will be in-serviced	
		at time, the eye drops		relating to the importance of	
		e used for 30 days after		assuring that all drugs and	
	1	s acca for oc days after		biologicals are locked securel	
	opening.			unless within direct supervision the nurse. The in-service will	on or
				The nurse. The in-service will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			00	(X3) DATE SURVEY COMPLETED
		155773	A. BUILDING B. WING		06/13/2012
	PROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP CODE ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-25(k) 3.1-25(l)			address assuring that the medications are secure and the any expired medications are disposed of properly. Nursing administration, via routine rout will be observing to assure the medications are kept secure. It addition, the consultant pharmacist will be asked to as with the monitoring of expired medications. How will the corrective action be monitor to ensure the deficient practic will not recur, ie, what quality assurance program will be pinto place? The corrective action that the monitor performance assure compliance through quality assurance is: A Performance Improvement To has been initiated that will be utilized to randomly review throughout theweek to assure that medications are secured properly. The tool will also randomly review to assure that there are no expired medication can the Director of Nursing, or designee, will complete this to weekly x3, monthly x3, then quarterly x3. Any areas identificiated in the medication can the audit will be immediate corrected. The Quality Assura Committee will review the tool the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic change will be completed: July16, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20	nds at an asist ed dice y ut tion to ol t ons rt. ol ied ely nce at ng

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Event ID: OZJH11

Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU			(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DI	NC	00	COMPL	ETED
		155773	A. BUILDI	NG		06/13/	2012
			B. WING				
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRACI	E AT SOLARBRON	I THE	Į E	EVANS\	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	 	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
		ESC IDENTIFY THAT IN ORMATION)	+ '	AG .			DATE
F0441	483.65	NTBOL BBEVENT					
SS=D		NTROL, PREVENT					
	SPREAD, LINEN	establish and maintain an					
	-	Program designed to					
		anitary and comfortable					
		I to help prevent the					
		d transmission of disease					
	and infection.	d transmission of disease					
	and inicotion.						
	(a) Infection Con	itrol Program					
		establish an Infection					
	Control Program						
	(1) Investigates, controls, and prevents						
infections in the facility; (2) Decides what procedures, such as							
		be applied to an individual					
	resident; and	• •					
	·	ecord of incidents and					
	` '	s related to infections.					
	(b) Preventing S	pread of Infection					
	(1) When the Info	ection Control Program					
	determines that	a resident needs isolation to					
	prevent the spre	ad of infection, the facility					
	must isolate the	resident.					
	(2) The facility m	ust prohibit employees with a					
	communicable d	isease or infected skin					
		ct contact with residents or					
	their food, if dire	ct contact will transmit the					
	disease.						
	` '	ust require staff to wash their					
		direct resident contact for					
		hing is indicated by accepted					
	professional prac	ctice.					
	(-) Lin -						
	(c) Linens	bandla stara ma					
		handle, store, process and					
	transport linens s	so as to prevent the spread					
			F0441				07/1//2012
	Based on obse	rvation and record	F0441		F441 What corrective action(-	07/16/2012
	review, the faci	lity failed to ensure			will be accomplished for thos	se	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		1	CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	infection contro	ol procedures were			residents found to have been	า	
	followed for 1 c	of 5 residents observed			affected by the deficient		
	for personal ca	re in that, glove use			practice? It is the practice of		
	was not done as required. (Resident				Solarbron to assure that all procedures are conducted in a		
	#73)				manner that is in accordance		
	0)				infection control guidelines. T		
	Findings includ	le:			corrective action taken for those		
		ic.			residents found to be affected	by	
	On 6/7/12 at 2:	25 a.m., CNA #3 was			the alleged deficient practice		
		· ·			include: Resident #73 is now	_	
	observed giving Resident #73 a bath.				receiving services in a manner that follows acceptable	ſ	
	CNA #3 had washed her hands and				parameters of infection contro	ı	
	applied her gloves. CNA #3 placed a				How will other residents hav		
	dry, clean towel under Resident #73's				the potential to be affected b	_	
	_	ved the resident's			the same deficient practice b	-	
	gripper socks a	and TED			identified and what correctiv	e	
	[thromboembol	lic deterrent] hose from			actions will be taken? Other		
	the resident's lo	ower legs and feet.			residents that have the potent	ial	
	CNA #3 washe	ed the resident's lower			to be affected have been		
	legs and feet a	nd then dried them.			identified by: All residents are now receiving services in a		
	_	the same gloves, CNA			manner that follows acceptable	e	
	_	on to the resident's			parameters of infection contro		
	lower legs and				What measures will be put in		
	_	hose. The CNA			place or what systemic		
		ashcloths and towel.			changes will be made to		
					ensure that the deficient		
		as assisted to the side			practice does not recur? The		
	-	ced a gait belt around			measures or systematic chang that have been put into place to		
		vaist, and applied her			ensure that the alleged deficie		
		sident was ambulated			practice does not recur include		
		n with her rolling walker			An in-service will be conducted	d	
		of the CNA. The CNA			for all nursing staff relating to		
	changed her gl	oves and washed her			proper infection control practic		
	hands. CNA#	3 placed the gait belt			The in-service addresses prop	er	
	around the resi	ident's waist and			handwashing and proper changing of gloves. The facility	.,	
	assisted the re	sident onto the			will be randomly observing sta		
	commode. CN	A #3 removed the			that is providing services to		
			1		l ' -		

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PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER		STREE 1701	ET ADDRESS, CITY, STATE, ZIP CODE MCDOWELL RD NSVILLE, IN 47712	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	the same glove to wash the resareas. Her back washed and drapplied by the bilateral axillae gait belt around and stood their commode. Why gloves, CNA was resident's perial applied cream buttocks. The were not washed resident back of The CNA obtain clothes and why the items into the proceeded to publicate clothing was applaced into her assistance of CNA #3 remove washed her had the policy on the complex of the policy on the policy of th	wheelchair with the ENA #3. At this time, ed her gloves and ands. see of gloves, dated ined on 6/8/12 at a the R.D. [registered ated gloves should be		assure that proper infection control protocol is followed in accordance with the facility phow will the corrective active monitored to ensure the deficient practice will not refer ie, what quality assurance program will be put into plate. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observation of proper infection control procedures during the provision of services. The Direction of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly Any issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedimeetings with recommendation as needed. The date the systemic changes will be completed: 7-16-12	olicy. on ecur, ce? ore ves 5 d to ector x3.

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Event ID: OZJH11

Facility ID: 010930

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155773	B. WING		06/13/2012
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE ICDOWELL RD	
TERRAC	E AT SOLARBRO	N THE	EVANS	SVILLE, IN 47712	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	The policy ind washed when and when the in doubt. The should be use linen, when to	d mucous membranes. icated hands should be activity is completed integrity of the glove is policy indicated gloves d for handling soiled uching body fluids, and aminating activities.			
	2003 and obta p.m. from the should be was	handwashing, dated ained on 6/8/12 at 12:23 R.D., indicated hands shed after contact with y secretions and ds are soiled.			
	3.1-10(1)				
R0000					
	_	State Residential cited in accordance 16.2-5	R0000	Bysubmitting the enclosed material we are not admitting truth oraccuracy of any speci findings or allegations. We reserve theright to contest the findings or allegations as par anyproceedings and submit to responses pursuant to our regulatoryobligations. The fact request that the plan of corresponsidered our allegation of compliance effective July 16, 2012 tothe annual licensure survey conducted on June 4 through June 13, 2012	e t of these cility of

State Form Event ID: OZJH11 Facility ID: 010930 If continuation sheet Page 45 of 50

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	00	COMPL	ETED
		155773				06/13/	2012
			B. WIN		ADDRESS STATE OF CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRAC	E AT SOLARBRON	ITHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CAMPENIA DA LA CEL GORDE CONTROL		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
R0027	410 IAC 16.2-5-1	<u> </u>					
110027	Residents' Right	· /					
	_	ve the right to a dignified					
		etermination, and					
		vith and access to persons					
		de and outside the facility.					
		the right to exercise their					
		ent of the facility and as a					
		nt of the United States.					
		rvation, interview, and	R00	27	F027 What corrective action(-	07/16/2012
		the facility failed to			will be accomplished for thoresidents found to have been		
	ensure 3 of 5 re	esidents observed for				1	
	care in a sampl	le of 7 were not able to			affected by the deficient practice? It is the practice of		
	•	ight to determine their			Solarbron to assure that		
		Residents #206, #214,			resident's rights are honored		
	,	(C3IGCITIS #200, #214,			related to their choice for waki	na	
	#228)				time. The correction action tai	-	
					for those residents foundto be		
	Findings includ	e:			affected by the alleged deficie		
					practice include: Residents#20		
	1. The clinical	record of Resident			#214, and #228 are awakened		
		wed on 06/11/12 at			per their choice. How will other		
					residents having the potential		
	•	record indicated the			to be affected by the same		
	_	uded, but were not			deficient practice be identifie	ed	
	limited to, atrial				and what corrective actions		
	bradycardia [a	heart condition with			will be taken? Other residents	3	
	low pulse rate].				that have the potential to be		
					affectedhave been identified b	-	
	During the initia	al tour on 06/11/12 at			All residents will be reviewed a	and	
	_	#1 indicated Resident			are being awakened in		
					accordance with their choice.	.4.	
		viewable and required			What measures will be put in	πο	
		of one staff for ADL's			place or what systemic		
	[Activities of Da	aily Living] and mobility.			changes will be made to		
					ensure that the deficient practice does not recur? The	<u> </u>	
	The Noc [Night	Shiftl Care			measures or systematic change		
		t provided by RN #1 on			that have been put into place t		
		•			ensure that the alleged deficie		
	00/11/12 at 10:	30 a.m. indicated,			practice does not recur include		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETE	ED
		155773	B. WIN			06/13/20	12
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	OMPLETION
IAG		R LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	dent #214] Noc [Night			All residents have been interviewed and they will be		
		5:30 am [sic] & [and]			awakened in accordance with		
	dressed T-W-F-Sat-Sun [Tuesday,				their choice. The care sheets		
	Wednesday, Friday, Saturday,				have been updated to reflect to	heir	
	Sunday]."				choice of awakening. The nurs	ses	
					and CNA's will be in-serviced		
	The Daily Care	Sheets, provided by			related to honoring the resider	nt's	
	RN #1 on 06/11/12 at 10:30 a.m., indicated, "[name of Resident] Noc to				preferences. How will the corrective action be monitor	od	
					to ensure the deficient practi		
	_	ed (Non-Hospice			will not recur, ie, what quality		
	days)."	(· · · · · · · · · · · · · · · · ·			assurance program will be p		
	dayo).				into place? The corrective act		
	Pesident #21/	was observed on			taken to monitor performance	to	
		:00 a.m. sitting in a			assure compliance through		
		_			quality assurance is: A		
		nis room. During an			Performance Improvement To has been initiated that	OI	
		at time, Resident #214			randomlyinterviews 5 residents		
		entered his room early			related to their choices of	,	
	_	get up for the day.			awakening being honored. The	e	
		stated, "but I don't			Director of Nursing, or designe	ee,	
	like to get up a	nd not do anything for			will complete this tool weekly		
	two to three ho	oursI don't think it's			monthly x3, then quarterly x3.	Any	
	necessary, the	y come in and wake			issues identified will be immediately corrected. The		
	me up at 5:00-	5:30 a.mI don't do			Quality Assurance Committee		
	anything, I just	sit hereTheir			willreview the tools at the		
		portant, but mine is			scheduled meetings with		
	too"	.,			recommendations as needed.		
					The date the systemic chang	es	
	In an interview	with DoN [Director of			will be completed: 7-16-12		
		/12/12 at 2:46 p.m.,					
		he list of residents that					
	, ,	up is "it's a list of					
		e easy to donot set in					
	•	on't want to get up they					
		to go to the next					
	one"						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155773	B. WIN			06/13/	2012
NAME OF E	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TANKE OF T	ROVIDER OR SOLVEIE				CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	0 Desire a Head	-4:-14					
	_	nitial tour on 06/11/12					
	at 9:45 a.m., R						
	Resident #206						
	between 10:00	a.m. to 10:30 a.m.					
	The Daily Care Sheets for Unit 5, provided by RN #1 on 06/11/12 at						
	•	licated Resident #206					
	•	ent with toileting,					
	transfers, and assist as needed with ADL's [Activities of Daily Living].						
	ADL'S [Activitie	es of Daily Living].					
	During a medic	cation pass observation					
	_	10:25 a.m., LPN #1					
		to prepare medications					
		206. LPN #1 indicated,					
		· · · · · · · · · · · · · · · · · · ·					
	at that time, the						
	_	nedications later in the					
	_	ise the resident liked to					
	sleep in.						
	On 06/12/12 at	t 10:35 a.m., LPN #1					
		to enter the room of					
		and rouse the resident					
		sident #206 indicated,					
	•	don't want to get up"					
		oserved to continue to					
		lent until 10:40 a.m. At					
		esident was observed					
	· ·	de of the bed, take the					
		d return to a lying					
	· · · · · · · · · · · · · · · · · · ·	, 0					
	· .	bed. During an					
		at time, Resident #206					
	indicated, "I jus	st like to sleep."					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155773	B. WIN			06/13/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R					
TERRACE AT SOLARBRON THE			1701 MCDOWELL RD EVANSVILLE, IN 47712				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)						DATE
	3. On 6/11/12 at 2:35 p.m., Resident		R00	27	F027 What corrective action(-	07/16/2012
	#228 was observed in his room in a chair				will be accomplished for those		
	with eyes closed, leaned back,				residents found to have been	า	
	wanderguard in place, and call necklace			affected by the deficient			
	• •			practice? It is the practice Solarbron to assure that			
	on.			resident's rights are			
					related to their choice for waking		
	An observation was made on 6/12/12 at			time. The correction action		_	
	09:55 a.m. of Resident #228 in his room,				for those residents foundto be		
	eyes closed, sitting in lazyboy, with			affected by the alleged de			
	wanderguard in place, and call necklace			practice include: Residents#		06,	
	in place.			#214, and #228 are awakened as			
	in place.			per their choice. How will other			
	On 6/12/12 at 11:45 a.m., CNA #4			residents having the potential		a <i>l</i>	
		-			to be affected by the same		
	-	Aide] and CNA #5 were			deficient practice be identifie	ed	
	observed transferring Resident #228 to			and what corrective actions will be taken? Other residents		_	
	the toilet and back to a wheelchair. After			that have the potential to be		•	
	toileting, Resident #228 was washing his		affectedhave been identified		v.		
	hands, and he then yawned and stated		All residents will be reviewe		•		
	"they got me up too early."			are being awakened in			
	they got me up too earry.				accordance with their choice.		
	An interview was done with CNA #4 at				What measures will be put in	ito	
					place or what systemic		
	6/12/12 at 11:55 a.m. CNA #4 indicated				changes will be made to		
	night shift usually gets Resident #228 up				ensure that the deficient		
	in the morning. The CNA indicated it				practice does not recur? The		
	was night shift's responsibility to get as				measures or systematic change		
	many people up on the unit in the				that have been put into place to ensure that the alleged deficient		
		ible, so day shift does not			practice does not recur include		
					All residents have been	-	
	have as many pe	opie to get up.			interviewed and they will be		
					awakened in accordance with		
		ed Daily Care Sheets,			their choice. The care sheets		
	dated 6/7/12 and provided by the DoN			have been updated to refle			
	[Director of Nur	sing], indicated Resident			choice of awakening. The nurs	ses	
		gotten up by the night			and CNA's will be in-serviced		
	shift, which is 2:00 a.m 6:00 a.m.				related to honoring the resider	IT S	
	Sillit, Willell 15 4.	a.m 0.00 a.m.	1		preferences. How will the		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER: 155773	A. BUILDING 00		COMPLETED 06/13/2012		
		100110	B. WING	ADDRESS STATE	00/13/2012		
NAME OF F	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE			
TERRAC	E AT SOLARBRON	I THE	1701 MCDOWELL RD EVANSVILLE, IN 47712				
(X4) ID	X (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TE COMPLETION DATE		
TAG	The policy and p Residents' Rights Administrator or indicated, "Res self-determina facility. Resident exercise their rig	procedure for Residential s, provided by the n 06/11/12 at 10:00 a.m., sidents have the right to attion, inside the atts have the right to this as a resident of the citizen or resident of the	TAG	corrective action be monitor to ensure the deficient pract will not recur, ie, what quality assurance program will be pinto place? The corrective act taken to monitor performance assure compliance through quality assurance is: A Performance Improvement To has been initiated that randomlyinterviews 5 resident related to their choices of awakening being honored. The Director of Nursing, or designe will complete this tool weekly monthly x3, then quarterly x3. issues identified will be immediately corrected. The Quality Assurance Committee willreview the tools at the scheduled meetings with recommendations as needed. The date the systemic change will be completed: 7-16-12	ed ice y ut tion to ol s eeee, k3, Any		

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